

Patient Name: _____

County: _____

Amebiasis Investigation Form
Arizona Department of Health Services

Symptomatology

1. Which of the following symptoms did you have?

>3 loose stools <input type="checkbox"/> Yes <input type="checkbox"/> No	Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	
# days (>3 loose stools) _____	highest temperature _____	date _____
# episodes in 24 hours _____	Chills <input type="checkbox"/> Yes <input type="checkbox"/> No	
Blood in stools <input type="checkbox"/> Yes <input type="checkbox"/> No	Headache <input type="checkbox"/> Yes <input type="checkbox"/> No	
Pale/Greasy <input type="checkbox"/> Yes <input type="checkbox"/> No	Backache <input type="checkbox"/> Yes <input type="checkbox"/> No	
Abdominal cramps <input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle aches <input type="checkbox"/> Yes <input type="checkbox"/> No	
Nausea <input type="checkbox"/> Yes <input type="checkbox"/> No	Fatigue <input type="checkbox"/> Yes <input type="checkbox"/> No	
Vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No	Other: _____	

2. When did your symptoms start? Date _____ Time _____ a.m. p.m.
3. What date did the diarrhea start? Date _____ Time _____ a.m. p.m.
4. Were you hospitalized? ☐ Yes ☐ No Adm Date _____ # days _____
5. How long did your illness last? _____ # of days to full recovery

Occupation

6. Work at or attend child care? ☐ Yes ☐ No
7. Food handler (work or volunteer)? ☐ Yes ☐ No
Household member is a food handler? ☐ Yes ☐ No
8. Provide patient care? ☐ Yes ☐ No

Food Habits

9. Are you a vegetarian? ☐ Yes ☐ No
Type _____

Medical History

10. Have existing chronic medical problem(s) or any medical condition(s)? ☐ Yes ☐ No
Describe _____

Within the last month:

11. Antibiotics ☐ Yes ☐ No
Name _____ dosage, # of days _____

12. Antacids (Tums, Mylanta, Tagamet, Prilosec, Pepcid, Zantac, Pepto bismol)? ☐ Yes ☐ No

Risk factors:

In the 7 days prior to your illness, were you exposed to any of the following:

13. Contact with :
Farm animals ☐ Yes ☐ No
Petting zoo animal ☐ Yes ☐ No
Pets (including hedgehogs) ☐ Yes ☐ No
What kind of animal(s) _____
When? _____ Where? _____
If the pet is a dog was it exposed to untreated water? ☐ Yes ☐ No

Were any pets ill with diarrhea? ☐ Yes ☐ No

14. Any travel? ☐ Yes ☐ No
Where? _____
From? ____/____/____ to ____/____/____
Airline? _____ Flight No. _____
Foods eaten on:
Outbound Flight _____
Return Flight _____

15. Contact to someone with diarrhea? ☐ Yes ☐ No

Name & relationship? _____

When? _____

16. Attend any gatherings (wedding, reception, festival, fair, convention, etc.)? ☐ Yes ☐ No
When? ____/____/____ Where? _____
When? ____/____/____ Where? _____

17. Get your face wet in the a lake, river, pool or spa? ☐ Yes ☐ No

Where? _____

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ADHS Giardiasis Investigation Form

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Food History

During the 7 days prior to your illness (give the day and date to orient the patient):

18. Where and what did you eat? List below. Attach additional paperwork as necessary.

Date	Foods & Drinks Consumed	Where? (if restaurant, list location)
	Breakfast Lunch Dinner Snacks	
	B L D S	
	B L D S	
	B L D S	
	B L D S	
	B L D S	
	B L D S	

In the 7 days prior to your illness, did you consume any of the following:

19. Raw sprouts (alfalfa, clover)? ☐ Yes ☐ No

Brand/Where bought? _____

20. Raw (unpasteurized) milk or dairy product?

☐ Yes ☐ No

Brand/Where bought? _____

21. Untreated or raw water?

☐ Yes ☐ No

Where? _____

22. Use water from a well?

☐ Yes ☐ No

23. Is your water filtered?

☐ Yes ☐ No

24. Who supplies your water? _____

That completes the questionnaire, thank you very much for your help. The information you have provided will be a great assistance to our investigation. Thank you again, we appreciate your assistance.

Interviewer: _____ Date: _____

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